FORM APPROVED Illinois Department of Public Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING: _ B. WING IL6010664 09/21/2020 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1251 EAST RICHTON ROAD ST JAMES WELLNESS REHAB VILLAS **CRETE, IL 60417** SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PREFIX PREFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) S 000 **Initial Comments** 2077353/IL126869- F689 G **Final Observations** S9999 S9999 Statement of Licensure Violations: 300.610a) 300.1210b)5) 300.1210d)6) 300.3240a) Section 300.610 Resident Care Policies a) The facility shall have written policies and procedures, governing all services provided by the facility which shall be formulated by a Resident Care Policy Committee consisting of at least the administrator, the advisory physician or the medical advisory committee and representatives of nursing and other services in the facility. These policies shall be in compliance with the Act and all rules promulgated thereunder. These written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, as evidenced by written, signed and dated minutes of such a meeting. Section 300.1210 General Requirements for Nursing and Personal Care The facility shall provide the necessary b)

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

each resident's comprehensive resident care

plan. Adequate and properly supervised nursing care and personal care shall be provided to each

care and services to attain or maintain the highest practicable physical, mental, and psychological well-being of the resident, in accordance with

Electronically Signed

TITLE

Attachment A

Statement of Licensure Violations

(X6) DATE 10/05/20

PRINTED: 11/15/2020 **FORM APPROVED**

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED						
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S9999	care needs of the remeasures shall incleded following procedures 5) All nursing encourage resident transfer activities a effort to help them practicable level of d) Pursuant to nursing care shall is following and shall seven-day-a-week 6) All necessate to assure that the reast ree of accident nursing personnels that each resident and assistance to personal standard assistance	e total nursing and personal esident. Restorative ude, at a minimum, the es: personnel shall assist and is with ambulation and safe soften as necessary in an retain or maintain their highest functioning subsection (a), general neclude, at a minimum, the be practiced on a 24-hour, basis: ary precautions shall be taken esidents' environment remains hazards as possible. All shall evaluate residents to see receives adequate supervision prevent accidents. Abuse and Neglect see, administrator, employee or hall not abuse or neglect a 2-107 of the Act) were not met as evidenced ion, interview and recordialed to transfer resident in a	S9999	DEFICIENCY							
	sustaining acute he	resulted to the resident (R4) ematoma in the left lateral leg emergency embolization									

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Illinois Department of Public Health (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: C B. WING 09/21/2020 IL6010664 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1251 EAST RICHTON ROAD ST JAMES WELLNESS REHAB VILLAS **CRETE, IL 60417** PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (X5) COMPLETE (X4) ID (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX CROSS-REFERENCED TO THE APPROPRIATE DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) S9999 S9999 Continued From page 2 This applies to 1 resident (R4) reviewed for transfers. The findings include: R4 is a 67-year-old resident who has multiple medical diagnoses to include weakness and unsteadiness on the feet. R4's Minimum Data Sheet (MDS) dated 7/22/20 showed that R4 is alert and oriented and requires extensive assistance with transfer. On 9/15/20 at 2:10 PM, R4 was resting in bed with her left lower leg wrapped with wound dressing. R4 gave the following statement: "I was going to sit in the chair. V11 (Certified Nursing Assistant/CNA) and V12 (Nurse) transferred me from bed to the chair with a white sheet/white blanket. While they were hoisting me from bed to chair. V11 lost her grip on the sheet which was holding my left leg, causing my leg to hit the left leg of the chair. It was so painful, I screamed, and I saw my left leg getting bigger and swelling up. They called the ambulance and I was brought to the hospital. I underwent an immediate procedure (embolization) to stop the bleeding. The doctor told me that I sustained 3 holes in my arteries and if the arteries did not get fixed, I would have lost my life or my leg. I know what a gait belt is and they (V11 and V12) did not use it on me during that time. I didn't tell anyone here about what really happened because I don't want to put anyone in trouble and I get along well with them (staff) here. But I had to tell the doctor in the hospital the truth when they interviewed me so they could figure it out what treatment they're going to give me." On 9/16/20 at 9:55 AM, R4 gave the same statement that she had given the day before with

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STATEMENT OF DEFICIENCIES (X1) PR

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED							
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S9999	Continued From page 3		S9999			*						
39999	regards to her leg i (Wound Care Nurs R4's dressing has I through from her he the dressing, it reve hematoma in her le below the side of th the ankle which me centimeter (cm) x openings (one in th part) in the hemato red blood. R4 was wound care as evice	ncident. At 10:22 AM, V5 e) provided wound care to R4. blood stains which had seeped ematoma. When V5 removed ealed a dark purplish/blackish eft lateral leg, located just ne left knee extending down by easured as Length (L) 25.5 15.8 (cm). There were two ne upper and one in the lower oma which were excreting dark in pain and anxious during dence by her grimacing facial ermittent verbal expression of										
	Assistant/CNA) statransferred R4 from R4's feet were both fully bearing her woof sitting in the chapain. R4's left leg stated that there would that there would be stated to R4's on 9/16/20 at 12:3 she (V12) and V11 with a gait belt. R4	20 AM, V11 (Certified Nursing ated that she and V12 (Nurse) in bed to chair with a gait belt. In on the floor, but she was not eight. About 2-5 minutes later air, R4 started screaming in started to fill up and was getting V12 immediately. V11 also was no incident that happened if she didn't know why it left leg. 25 PM, V12 (Nurse) stated that a transferred R4 into the chair couldn't fully stand. R4 was ton the floor and pivot. She		FJ		2						
3	only had partial we leg anywhere during started filling up who but she looked neuron 9/16/20 at 1: 2 Physician) gave the	eight bearing. R4 did not hit her ng transfer. When R4's leg ith fluids, she was not crying		6								

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Illinois Department of Public Health (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: _ C B. WING 09/21/2020 IL6010664 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1251 EAST RICHTON ROAD ST JAMES WELLNESS REHAB VILLAS **CRETE, IL 60417** PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (X5) COMPLETE (X4) ID (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG **DEFICIENCY**) S9999 Continued From page 4 S9999 asked R4 what had happened to her leg but R4 told him that she didn't know. There are two openings in the hematoma one in the superior and one in the inferior area. V13 saw it on 9/15/20 and measured it as (L) 25.3 cm x (W) 17 cm. R4's hematoma can only be caused by trauma unless R4 is taking a serious anti-coagulant (blood thinner) medication. However, R4 has no anti-coagulant except for the Aspirin. R4's laboratory result showed that her INR and PTT are normal. So V13's conclusion is that the hematoma could have happened due to trauma. Hospital Record dated 8/31/20 Showed: R4 was admitted with left lower extremity acute hematoma. R4 states that she was being moved in bed when the left lateral side of her leg below the knee hit the side of the bed. R4 stated that she has instantaneous pain and noticed very quickly that the leg began to swell. R4 was brought into the emergency room for further evaluation. On arrival a large left lateral leg below the knee hematoma was noted. Hemoglobin was within normal limits. CT angios done showing subcutaneous hematoma. Physician reviewed this with interventional radiologist. Ultimately R4 was taken to interventional radiology lab where embolization of the left anterior tibial artery runoff was done. Procedure: Arterial Embolization CT Angiography to Left Lower Extremity Findings: A soft tissue mass present in the anterior left lower leg measuring 23 cm x 11 cm x 4 cm. The mass is mostly soft tissues with serpiginous calcification and enlarged venous structures noted throughout. The mass extends to the skin. The mass does not extend to the deep fascia osseous structures of the lower leg.

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(A)

emergency or unavoidable circumstances,

manual lifting is not permitted.

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